reviews

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La Tendresse

Ken Strauss

Black Ace Books, £16.95, pp 287
ISBN 1 87298842 3
http://blackacebooks.com/

Rating: ★★★

This first novel by American doctor Ken Strauss attempts, through a complicated narrative conceit, to craft a wartime love story and a medical anti-war treatise. It succeeds in doing both, in part.

The unnamed contemporary narrator has just bought and begun to renovate a château on the French-Belgian border. He uncovers a diary hidden behind a high chimney wall. The diary was written by an English surgeon whose life, loves, and losses spanned the first half of the 20th century, and whose destiny it was to serve in both world wars. The château was used as a British field hospital where the surgeon worked during the autumn of 1917 and then later became his home and refuge during the interwar period up to the time of his execution by the Germans in 1944.

Only a minimum suspension of disbelief is required to accept the notion that the diary is also an epistolary record (the surgeon kept carbon copies of important letters tucked into its leaves), a medical analysis of war surgery circa 1915-18, a notebook of children's stories (some by the surgeons, some by others), and a collection of poems (again some by the surgeon, some by others). Without much ceremony, the reader is invited into this oscillating jumble of text to witness the intimate thoughts of a young man who is learning to love women and the reactions of a young surgeon who is struggling to make sense of his trade on the Western Front.

It takes a deft hand to write a love story set in wartime. The great novels of this genre establish high standards for three difficult literary tasks: conveying the context, in all its complex span and horror; sustaining the significance of the personal, played out against tragedy on a grand scale; and holding the reader through the transition from one level to another. The best in this tradition for the first world war, in my view, include the classic *All Quiet on the Western Front* (by Eric Maria Remarque) and the much more recent *Birdsong* (by Sebastian Faulks). For the second world war, there are still none to rival (again in my view) *The Young Lions* (by Irwin Shaw) or *War and Remembrance* (by Herman Wouk).

La Tendresse works relatively well as a love story. During the time the protagonist comes of age, moves through training, and grapples with his field assignment just before the battle of the Somme, he meets and falls in love with an overlapping succession of four vibrantly rendered women. Their stories intersect with his in moving, albeit predictable ways. The central theme of the novel, that human connection attests to the quality of life lived, courses defiantly through the depicted years of wartime loss.

As a medical perspective on war, the novel is less satisfying. It is always hard to capture the ways in which medicine and war coexist in uneasy equilibrium. Although it is a well established historical fact that much innovation in medicine and science is spurred by the marshalling of social resources in war, it is also a cold fact that the aim of war rapidly devolves into killing human beings. This aspect of the enterprise is one that military physicians and surgeons must constantly struggle with. How long they cope, with what discipline of mind and spirit, depends on the individual and on the war experience.

Approaching these issues through fiction, particularly through the eyes of a doctor, demands a clinical tone, a scientific eye for detail, and a capacity for encapsulating understatement. In *La Tendresse*, despite the experiment with many different texts and tones, the author does not accomplish this shift. The medical mind of the protagonist is insufficiently developed in the novel to permit an interesting intellectual or moral confrontation with the overwhelming casualties of the first world war. Nor is the overall clinical setting described in enough substantive detail to drive a sense of drama, the taut issues of triage, the team and chain of command, the failures under stress. We do not see the doctor as decision maker, only as sentient layman.

Yet with these shortcomings, the novel still commands the reader's attention to the end. The years have carried us further away from the events that give rise to this story but they have not eased their pain or influence. The storyline of one man's anguish pays suitable homage to the enduring disbelief with which we look back on this time and to the myriad ways in which the 1914-45 period has affected our collective memory and explanation. And by tracing the intricately awful ways that men are mown down in battle and people lose people they love, the author ably communicates the cumulatively simple way in which war is hell. In the post September 11 world, that communication could well stand repeating.

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Hit parade bmj.com

These articles scored the most hits on the *BMJ*'s website in the week of publication

SEPTEMBER

1 **Editorial: Efficacy and safety of COX 2 inhibitors**
2002;325:607-8
7731 hits

2 **ABC of psychological medicine: Musculoskeletal pain**
2002;325:534-7
4972 hits

3 **Editorial: Average length of stay, delayed discharge, and hospital congestion**
2002;325:610-1
4813 hits

4 **Editorial: Outcome after cardiac arrest outside hospital**
2002;325:503-4
4573 hits

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2002;325:514
4399 hits

6 **Education and Debate: Alosetron: a case study in regulatory capture, or a victory for patients' rights?**
2002;325:592-5
4334 hits

7 **News: Doctors fail to see the joke**
2002;325:561
4316 hits

8 **Editorial: When medical students go off the rails**
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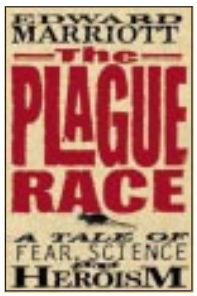
4039 hits

9 **Editorial: What's a good doctor, and how can you make one?**
2002;325:667-8
3898 hits

10 **News roundup: Junior doctor charged with manslaughter after medical error**
2002;325:616
3718 hits

The Plague Race: A Tale of Fear, Science and Heroism

Edward Marriott



Picador, £14.99, pp 316
ISBN 0 330 48318 8

Rating: ★★

To most people, the plague is synonymous with the most terrifying of epidemics, the Black Death that killed 25 million Europeans between the 14th and 17th centuries—the original pestilence. Even today, the plague is regarded as one of the most feared infectious diseases. The outbreak in Surat, India, in 1994 caused panic throughout the country and the flight of up to 600 000 of the city's residents. Many countries responded by stopping flights to and from India. The plague's reputation has been further reinforced by discussion of its potential use as an agent of bioterrorism. Indeed, the plague was used as one of the earliest examples of biological warfare. During the siege of Caffa in 1346, the Mongols catapulted the remains of plague victims into the city and successfully started an epidemic among the defenders.

The Plague Race recounts the story of the discovery of the plague bacillus. In 1894 plague erupted in Canton and threatened to devastate Hong Kong. The colonial government of Hong Kong invited two bacteriologists to unlock the mystery of the cause of this disease. Shibasaburo Kitasato from Japan was clearly favoured by the governor of Hong Kong and was provided with every facility he desired. In contrast, the Swiss-born Alexandre Yersin was marginalised and ended up working in a shack in the grounds of one of the hospitals.

Within a few days of each other, both Kitasato and Yersin independently announced the isolation of the plague bacillus. Although Kitasato was initially credited with the discovery, it is now apparent that his claim was incorrect. The organism described by the methodical Yersin fits the description of what we now know as *Yersinia pestis*. Nonetheless, recognition for this achievement is still occasionally jointly awarded to both Kitasato and Yersin, and it was only in the 1960s that the genus *Yersinia* was named after Yersin.

This is a classic story of intrigue and scientific rivalry. The book is written in a journalistic style that enlivens the story, but the reader is left feeling that too much detail is missing. In particular, the reasons behind Kitasato's favoured status and Yersin's marginalisation are unclear. Kitasato's background is not presented in any detail for the reader to appreciate why he was so famous.

The author has padded out the story by periodically inserting a fictional story set in Surat, India, during the outbreak of plague in 1994, and brief accounts from present day Madagascar and New York City. Although these snippets are interesting, the story of the discovery of the cause and transmission of plague is fascinating in itself and could stand alone. In spite of these deficits, the book is still a compelling read.

SHERWIN CRASTO/AP PHOTOS

Tackling plague in India, 1994

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Biomarkers of Disease: An Evidence-Based Approach

Eds Andrew K Trull, Laurence M Demers, David W Holt, Atholl Johnston, J Michael Tredger, Christopher P Price

Cambridge University Press, £80, pp 516
ISBN 0 521 81102 3

Rating: ★

Reading the history of one's subject can be an illuminating and humbling experience. In the 1960s when the use of biochemical measurements in the diagnosis and monitoring of disease was still very much in its infancy, clinical biochemists were to the fore in advocating that we abandon the concept of the normal range in favour of the reference range. They actively promoted the concepts of false positive and false negative results. At a time when members of the public were given an impression that the white heat of technology would usher in an era of certainty, members of the profession were calling for more objective assessments in evaluations of the usefulness of biological markers in clinical practice. While "An evidence based approach to . . ." is currently a fashionable title, it is not a new concept.

Biomarkers of Disease: An Evidence-Based Approach is a "distillation of presentations made at the EMBODY 2000 Conference held in Cambridge." Those who have experience in organising the scientific programme for a meeting will know that it is frequently difficult to ensure that speakers address their remit. The quality and effectiveness of a presentation in the lecture theatre of a conference largely depends upon the use of special effects, projected images, and video clips and the body language and dramatic pauses of the speaker. In these settings the script is not paramount and can be disappointing when read.

The four chapters in the first part of the book address an evidence based approach to the evaluation of biomarkers, the development of biomarkers from an industrial perspective, statistical approaches to rational biomarker selection, and the use of intelligence systems in clinical decision support. The remaining 44 chapters are grouped into eight parts addressing nephrology, metabolic bone disease, hepatology, gastroenterology, toxicology, cardiology, neurology, and transplantation. As it could be argued that biological markers have had their greatest impact in endocrinology, its omission is surprising.

It is difficult to identify a readership for this publication. Those who look at the chapters in which they have a specific interest will be dissatisfied as the authors have not objectively assessed the quality of the data available to them. Many of the topics are not well referenced—16 of the chapters have 12 or fewer references. Those hoping to obtain an incisive assessment of a field in which they have little knowledge will also be disappointed.

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Items reviewed are rated on a 4 star scale (4=excellent)

Panorama: "The Secrets of Seroxat"

BBC 1, 13 October at 10 15 pm

Rating: ★

The postmodern media critic Jean Baudrillard once asserted that the Gulf war did not happen, and was only a televised simulation of a war. By the end of *Panorama*'s "The Secrets of Seroxat" my own grip on reality, never particularly strong, was faltering. This mental fragility disappointed me because I know quite a lot about selective serotonin reuptake inhibitors (SSRIs), having prescribed them, done research on them, and taken them. It may have been the nature of *Panorama*'s "secrets" that undermined me. For example, the *Shorter Oxford Textbook of Psychiatry* notes both the key issues raised in the programme, namely that SSRIs, particularly paroxetine (Seroxat), can cause unpleasant withdrawal symptoms and that early in SSRI treatment restlessness and agitation might increase the risk of suicidal behaviour.

Despite this it seems likely that clinicians and patients aren't sufficiently aware of these problems. *Panorama* featured the video diary of Helen Kelsall, which gave a superb account of how hard it can be for some people to stop SSRI treatment. However, far darker things were in store and at the centre of the programme was the kind of horrifying tragedy that depression can visit on its victims and their families. After being on paroxetine for two days retired American oilman Donald Shell shot and killed three members of his family (including his 9 month old granddaughter) before taking his own life. Such disasters have happened before SSRI treatment and will occur after SSRIs have left the scene. However, the family blamed the paroxetine and sued.

Tragedies like this have multiple causes and it is impossible to know for sure to what extent paroxetine might have played a role. However, *Panorama* staged its documentary as a thriller with David Healy as hero, a kind of psychiatric Philip Marlowe, walking the mean streets down which a man must go. Healy, reader in psychological medicine at the University of Wales College of Medicine, was interviewed under true *film noir* conditions; half his face was in darkness while the rest was lit like a Rembrandt. Later we saw him driving alone, grim jawed and dauntless, through a dark winding tunnel to the Harlow headquarters of GlaxoSmithKline, a soulless Lubyanka overhung with swirling banks of cloud. Healy's quest "bordering on the impossible" was to identify crucial documents in a sealed warehouse packed with a quarter of a million pieces of paper. These documents, which held the closely guarded secret that SSRIs can cause adverse effects in healthy volunteers, could win the case for the Shell family. Healy eventually arrived in a dark cavern, lined with boxes. Suddenly, there was light. The rest was history and six million dollars to the plaintiff.

BBC

Helen Kelsall's video diary showed how hard it can be to stop SSRI treatment

Of course, if there are heroes there must be villains and drug companies rival clearing banks and Saddam Hussein in public affection. Unfortunately for the company spokesmen, in the hyper-reality of television, choreographed anecdote will beat evidence based medicine every time. In the face of human misery and disaster, attempts to put depression, its treatment, and the risk of suicide in a statistical context only make you appear heartless and evasive.

Why are we sometimes slow to recognise drug problems and share our knowledge with colleagues and patients? Better information systems and the internet will help, but drug companies have two difficult missions: they must discover new, safe medical treatments and at the same time maximise profits for shareholders. These goals don't have to be incompatible because knowing about the possible problems of medications increases the likelihood that we will use them safely and well. However, company representatives can find it difficult to acknowledge weaknesses in their products. Perhaps the industry needs a new kind of marketing culture for a more informed and sceptical public.

Another factor peculiarly relevant to psychiatry is the stigma and misunderstanding that surround the illnesses and their treatment. For example, the narrator in the *Panorama* programme repeatedly referred to SSRIs as "happy pills," a term which trivialises depression and insults people taking medication. Now, who were the good guys again?

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PJC has received fees for lecturing and advising a number of drug companies that market antidepressant drugs including SSRIs.

WEBSITE OF THE WEEK

Alcohol screening A paper in this week's *BMJ* (p 870) describes some of the difficulties that doctors experienced when they tried to implement a screening programme to detect people who might have been drinking too much alcohol. One was discomfort with the inquisitorial and judgmental role that they had to play. Quite right, too. In the last analysis of occupational mortality in the United Kingdom, the medical profession was second only to publicans and veterinarians for deaths from cirrhosis of the liver.

You can find out what it feels like to be on the receiving end of an inquiry about drinking habits by going to www.alcoholscreening.org/index.asp, answering the AUDIT questionnaire, and getting the benefit of an immediate online evaluation. Be careful: this is an American website and an admission of more than 14 drinks a week will generate a warning that you may be at increased risk for health problems. As the International Center for Alcohol Policies (ICAP) (www.icap.org/publications/report1_supplement.html) explains, this is another example of the two countries being divided by a common language. While a unit of alcohol in the UK is defined as the equivalent of 8 g of ethanol, a standard US drink contains 14 g.

ICAP makes no secret of the fact that major producers of alcoholic beverages sponsor it and perhaps there are fewer conflicts of interest in the information about international variation in alcohol policies at Eurocare (www.eurocare.org/profiles/). Eurocare's homepage does not say anything about funding but it makes its purpose as a pressure group for the prevention of alcohol related harm in Europe clear. The site contains a lot of interesting stuff including a pamphlet, *Marketing Alcohol to Young People* (www.eurocare.org/publications.htm), strikingly compiled from advertisements that the drinks industry has used to seduce the young.

Before you boil with indignation at the cynical ways big business exploits vulnerable groups read Theodore Dalrymple's essay, "Absolut Puritanism" (www.opinionjournal.com/extra/?id=95001633). This was first published in the *Wall Street Journal* in response to the American Medical Association's angry protest at the National Broadcasting Corporation's decision to allow advertisements for liquor on its network. It's a witty attack on the view that advertising is effective in persuading people to do something that they didn't want to do in the first place.

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PERSONAL VIEW

Why I'm needled by thrombolysis target

Up and down the United Kingdom emergency departments are in crisis (again!) with senior managers and medical staff burning the midnight oil. The reason for this increased activity is the government's national service framework (NSF) for coronary heart disease (www.doh.gov.uk/nsf/coronary.htm). At present, the guidelines on thrombolysis in acute myocardial infarction are that 75% of patients should receive thrombolysis ("door to needle time") within 30 minutes. Many emergency departments currently struggle to reach these targets. However, these guidelines are due to change to 75% of patients receiving thrombolysis within 20 minutes by April 2003. This is not going to be easy to achieve and there are increased funds available from the Department of Health (as well as the potential for penalties for failure) in order that these targets are met. Many departments are looking at employing extra staff and using more expensive "bolus thrombolytics" in order to meet these targets. In short considerable reorganisation and expense is required.

Staff will be diverted from equally critically ill patients

Is all this effort worth it? Common sense would seem to indicate that the earlier thrombolysis is started the better—the so called "minutes mean myocardium" argument. However, there is a downside to decreasing the target times. As well as the extra resources required, the extra pressure on staff will increase the risks of inappropriate thrombolysis and thus risk considerably increasing the complication rate. Also, hard pressed staff will be diverted from equally critically ill patients to meet the guidelines.

Can the extra 10 minutes justify the potential problems?

Can the extra 10 minutes justify these potential problems? The government website references three papers in support of its target, none of which mentions the magical 10 minute figure. The main paper (*Lancet* 1996;343:771-5) talks in detail about the "golden hour." However, its authors showed a difference between patients treated in the 0-1 hour treatment delay and the 1-2 hour treatment delay groups. There was an average difference between these groups of 0.85 hours (not 10 minutes). It should also be noted that the paper published 95% odds ratios for these two groups, which overlapped considerably—that is, they failed to show a statistically significant difference. Nowhere have I read a paper that has shown a proven benefit from reducing thrombolysis by 10 minutes.

The authors of the NSF would no doubt claim that their "door to needle time" guidelines are only one of a number of strategies to reduce the "call to needle time" below 60 minutes. But where is the evidence that reducing this time period from, for example, 69 minutes to 59 minutes is of the magnitude of benefit that justifies the cost and effort involved?

Does this mean that such a benefit does not exist? Of course not—but the effect of the NSF is to spend a huge amount of resources on what is, effectively, a hunch. It is also true that considerable healthcare money is spent on other treatments and treatment strategies that are unproven. Indeed, it is often difficult to prove beyond doubt that even the most logical treatments work.

Could this money be better spent? The NSF mentions public education programmes to encourage people to call 999 in the event of suggestive symptoms of a myocardial infarct. This might well lower "symptom to needle" times but risks overloading an already stretched system—with the results that the assessment of the "worried well" might delay the treatment of the relatively small numbers of patients presenting with chest pain who require thrombolysis.

The NSF states that "thrombolysis should be available in A&E if direct CCU [coronary care unit] admission is not possible." Few would disagree with this, but it is surprising (given this statement) that the "external reference group" for the NSF consisted of only one emergency physician among 41 members listed. Is it possible that this has resulted in unrealistic expectations of what can be achieved in the average emergency department?

Readers appalled at my cynicism might ask how I would like my own impending myocardial infarction (precipitated by the stress of meeting the NSF guidelines) treated. The answer? I would like thrombolysis given as quickly and efficiently as possible—but only after the relevant healthcare professional has ruled out the acute dissection of the aorta that might be the cause of my symptoms. I fear that these new pressures will make that less likely.

On second thoughts, I would prefer primary angioplasty (*New England Journal of Medicine* 1999;341:1413-9)—now that really would be some long term thinking.

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SOUNDINGS

Spraying lawns and eating grass

Again and again we turn to the daily papers for news and inspiration. We learn that Americans are living longer than ever (mean of 74 years for men, 80 for women); 61% are overweight; infant mortality is at a low of 6.9 per 1000 live births; healthcare costs continue to rise; and a panel recommends that people should exercise at least one hour a day. They should also stay away from mosquitoes, now active in spreading the West Nile virus, especially to Illinois. Transmitted by mosquitoes from bird to bird, the virus has caused smaller outbreaks since 1999, but this year has assumed epidemic proportions—by early October more than 2700 cases in the United States (146 deaths) and more than 640 cases in Illinois (36 deaths).

The virus has spread to horses, squirrels, dogs, and wolves. In Chicago it has decimated the bird population, particularly crows, which have almost completely disappeared this year, and it has killed two geese and a turkey vulture at a city zoo. All over Chicagoland trucks have been spraying pesticides to eliminate the insect carriers; the archdiocese has asked Catholics not to adorn graves with flowers; and orthodox rabbis have lifted their interdict against killing animals (mosquitoes) on the Sabbath.

Then we read about chronic wasting disease, caused by prions and related to mad cow disease, so widespread in Wisconsin that authorities each year must kill thousands of deer. Spread by nose-to-nose contact, this fatal brain disease of deer has not affected humans. Nevertheless, some experts have warned against eating venison.

There has also been disappointing news for the $4.2bn (£2.68bn/€4.24bn) herbal supplements market. We read that recent studies have found no depression relief from St John's wort, no memory improvement from gingko, no cold prevention from echinacea, no weight loss from ephedra, no stress relief from kava, no cholesterol lowering from garlic—but many side effects, ranging from transient hypertension to severe liver damage. While regulators and health experts struggle with this problem, the public continues to exhibit an extraordinary faith in these "natural" remedies. The cynic Voltaire might have said that man's desire to eat herbs almost surpasses that of the common herbivores.

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